AFIP Molecular Diagnostics Laboratory

CYSTIC FIBROSIS TESTING REQUISITION FORM

Patient Information:

Patient Name: _____ Date of Birth: _____ Sex: (M/F) _____

Identification Number: _____ Date drawn: _____

Requesting Physician: _____

Phone: _____ Fax: _____

Address: _____

Indication for Testing:

_____Carrier Screening
Status of Partner:
_____ Untested
_____ Negative by mutation analysis
_____ Being tested concurrently
_____ Carrier of _____ mutation
_____ Confirmation of Diagnosis, Affected Individual
_____ Congenital Absence of vas Deferens
_____ Abnormal fetal ultrasound

Is there a family history of cystic fibrosis? Yes _____ No _____
If yes, list known affected family members and their relationship to the patient:

Patient Ethnicity:

_____ Caucasian _____ Hispanic

_____ Ashkenazi _____ Asian

_____ African American _____ Other

Has informed consent been obtained for the performance of this test?
Yes _____ No _____

Send completed form with specimen to:

AFIP Molecular Diagnostics Laboratory
Dept. of Cellular Pathology and Genetics
Bldg. 101, Rm. 1057
Armed Forces Institute of Pathology Annex
1413 Research Blvd.
Rockville, MD 20850-3125